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ABSTRACT

This paper presents a theoretical model for a primary prevention program for bulimia and anorexia nervosa to be used with adolescents and young women considered most at risk of developing these eating disorders. Characteristics of potential anorexics and bulimics are identified to aid in the selection of target groups for the program. It is recommended that subjects be paired by common characteristics and divided into experimental and control groups. It is noted that successful interventions in preventing anorexia and bulimia have not been identified yet. However, seven procedures are suggested as a starting point to be used with the experimental group: (1) taking subjects off reduction diets and teaching alternative ways of reducing or maintaining normal weights; (2) initiating some type of family therapy; (3) stressing relaxation training and/or stress management; (4) using a cognitive-behavioral approach to change irrational belief systems and inappropriate behaviors; (5) incorporating techniques found to be effective in treating anorexia and bulimia into prevention programs; (6) beginning treatment for anxiety or depression; and (7) continuing long-term follow-up until subjects reach an age when the risk of developing these disorders is reduced. Possible benefits from this type of intervention are discussed and possible problems in developing such a program are identified. It is concluded that, in spite of these problems, the implementation of primary prevention programs may reduce the incidence of these eating disorders and may prove more cost effective than traditional treatment procedures. (NRB)

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A Primary Prevention Program To Reduce Bulimia and Anorexia Nervosa

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Abstract

Bulimia and anorexia nervosa are eating disorders that primarily affect women. Despite recent public and professional attention, the incidence of these disorders seems to be increasing. Since these are very difficult to treat and often cause irreversible side effects, the authors, as an adjunct to treatment, suggest implementation of programs designed to prevent their occurance. A theoretical model for a primary prevention program is presented, together with possible interventions. Despite some predictable problems associated with such programs, the authors believe they will reduce the incidence of these eating disorders, and in the long run will be more cost effective than traditional treatment prodcedures.

A Primary Prevention Program To Reduce Bulimia and Anorexia Nervosa

Bulimia and anorexia nervosa are eating disorders that primarily affect women. Therapists who have dealt with these are well aware of how difficult they are to treat. Young women are often caught in the binge-purge cycle or starvation habit for years. Yet despite recent treatment and research efforts, the prevalence of these disorders seems to be increasing (Russell, 1979; Jones, Fox, Babigian, and Hutton, 1980; Maloney and Klykylo, 1983). In addition, the mortality rate for these ailments, either through suicide or physical deterioration is greater than all other psychiatric disturbances (American Psychiatric Association, 1980).

Since bulimia and anorexia are very difficult to treat, and because they can be associated with severe physical complications, this paper is an attempt to focus attention on a modality that has thus far received little professional consideration. Namely, the prevention of these disorders through early psychological intervention. It should be noted that this an exploratory paper since actual experimental manipulations are yet to be done. As the title indicates, the suggestions to be presented are theoretical in nature.

The eating disorders to be addressed are limited to bulimia and anorexia nervosa because these share some common characteristics, and possibly the same etiology. The terms bulimia and anorexia nervosa refer to these behaviors as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980). Binge eating (consumption of large amounts of food without purging or dieting), and obesity are not considered, even though some researchers feel that a similar mechanism is involved in all of these behaviors. In addition, the target group will be limited to women since they make up approximately 90 percent of anorexics and bulimics.

The prevention of psychiatric disturbances is not a new idea. It can be

traced back to at least the previous century, and like other psychological interventions, similar concepts can be found in ancient history (Watson, 1963). However, despite the recent community mental health movement, the use of preventative methods has never really caught on with mainstream mental health professionals. Recently, there seems to be a renaissance of prevention efforts in terms of government and professional interest (Heffernan and Albee, 1985), but it remains to be seen whether this develops into a major force in the field.

There are basically three types of preventive interventions: primary, secondary and tertiary. These three terms are typically translated into the common labels of prevention, treatment and rehabilitation. This paper limits itself to primary prevention, which deals with potential or predicted abnormal behaviors. Primary prevention can be defined as the reduction of the incidence of predicted disorders in the general population. Since the incidence of anorexia has been estimated as high as one in 200 females between the ages of 12 and 18 (Crisp, Palmer and Kulucy, 1976), and the incidence of bulimia was found to be between 4% and 13% among college populations (Johnson and Berndt, 1983), the prevention of these disorders seems to be a viable area for research.

One of the first steps involved in a primary prevention program is the selection of the target group. In some respects it might be ideal to treat the entire population in order to make sure that <u>everyone</u> who potentially may develop these disorders is treated. However this is not possible so selection of a population most "at risk" of developing these eating disorders is necessary. In order to help select this group, the following characteristics of potential subjects (based on recently published research) are identified.

The target group for anorexia nervosa would most likely be made up of white females between the ages of 12 and 18 coming from middle and upper class

backgrounds. This group would also have the following characteristics: 1) age span just prior to or shortly following puberty; 2) children whose mother or sisters have or had anorexia or other eating disorders; 3) children with a family history of affective disorders (e.g., depression or manic-depressive disorders); 4) children who are currently on a weight reduction diet; 5) children who currently binge-eat; 6) children who have ceased menstruating (since about 30% of anorexics do so prior to weight loss); 7) children who are not more than 10 to 20 percent above ideal weight; and 8), children who are morbidly afraid of gaining weight, or have a distorted body image. The target group may also include children with identified personality characteristics associated with with anorexia such as an obsessive-compulsive disorder.

The target group for bulimia shares many characteristics with the anorexic population. At risk children would most likely be made up of: 1) white middle and upper class girls between the ages of 14 and 20, and post-puberty; 2) children whose mother or sisters have or had other eating disorders; 3) children with a family history of affective disorders; 4) children who are currently on a restrictive diet; 5) children who currently binge-eat; 6) children with a history of being greater than 20 per cent above normal weight; and 7) children who are morbidly afraid of gaining weight, or have a distorted body image.

After selection of the target group, the next suggested step in this program is to match pairs of subjects which share common characteristics and then divide the subjects into a experimental and control group (Campbell and Stanley, 1966). The experimental group would of course receive the intervention, while the control group would not. Although some researchers may feel uneasy about not treating the control subjects, the lack of knowledge about the etiology of these disorders makes this crucial at this point in time. Thus a major emphasis of this prevention program should be to follow

both groups very closely in order to help identify the factors that lead to, or prevent these disorders.

In terms of intervention, it is not possible to say at this time what process will be most successful in preventing anorexia and bulimia. As noted above, a major goal of this program is to identify such information. However the following procedures are suggested as a starting point to be used with the experimental group, while the control group is followed without intervention.

1) All subjects should be taken off reduction diets, and taught alternative ways of reducing or maintaining normal weights. These may include exercise programs, proper nutrition training, or the use of permanent eating plans such as the Pritikin diet (Pritikin, 1981). Along with this, children should be taught realistic normal weight ranges for their age or adolescent stage. Of course, large weight deviations either or above or below normal should be discouraged.

2) Some type of family therapy, may be helpful in order to deal with some of the conflicts that seem to be present between parents and children with eating disorders.

3) Some type of relaxation training and/or stress management is suggested as part of the intervention.

4) A cognitive-behavioral approach may be useful in order to change irrational belief systems and inappropriate behaviors.

5) Any type of orientation or technique that has been shown to be effective in <u>treating</u> anorexia and bulimia may also prove to be useful in preventing the disorders.

6) Treatment for anxiety or depression.

7) Lastly, long term follow-up should be maintained as long as feasible, possibly until the subjects are in their mid to late 20's, when the risk of developing these disorders is reduced.

Some of the possible benefits from this type of prevention program may include a reduced incidence rate for these eating disorders among the intervention group; some badly needed information concerning the etiology of these disorders, including whether some of the physical or psychiatric symptoms associated with them are their cause or their outcome; increased early identification of children who already have these disorders; possibly reduced severity of disorders (if they do develop in spite of the intervention); increased efficacy of future treatment; and other psychological problems or disorders may be identified and/or prevented as well.

The preceding may seem like a fairly promising representation of a primary prevention program. However, anyone who has ever run a similar program knows of the myriad of problems and setbacks that may be encountered. One of the first major stumbling blocks may be getting the necessary funds needed for implementation. It seems it is a lot easier to justify funds for treatment of actual disorders than it is to get money for the prevention of future disorders that may never actually occur. This is true despite the probability that in the long run prevention programs are likely to be a great deal more cost-effective than treatment.

Another problem likely to be encountered is the selection of a proper experimental design to be used to evaluate the program. A major concern will be selecting the dependent measure. Although traditional experimental designs are often used in prevention studies, many problems are associated with their use. For example, the program may be effective in the sense that it has prevented further deterioration in the experimental group, but this difference is not likely to be noted using traditional statistical methods. Secondly, it may be argued that the intervention group should have a lower incidence of the disorder than the control group, but this leads to issues such as an

appropriate follow up period, as well as providing evidence that the disorders would have occurred without intervention. In addition, a number of other factors make such long term studies very difficult to fund, carry out and complete.

Another problem which may surface is that the subject and family may be unwilling to cooperate with the treatment of a problem that has not yet occured. One reason for this is the stigma often attached to any type of psychological intervention, even if it is meant to prevent future disorders. Similarly, there is at least a slight chance that preventive interventions may actually lead to or cause the disorders that they are designed to prevent. In addition, the accurate identification of a target group likely to develop the disorders brings with it a multitude of problems which obviously is paramount to the success of the program. Further, there are infinite bureaucratic problems such as getting referrals, cooperation with other agencies, relying on others to carry out the interventions or follow-up procedures, and many other obstacles that may plague such an effort (for a more complete description of problems likely to be confronted in a prevention program, see Cullari, 1981).

Despite such potential problems, we firmly believe that a preventive approach to eating disorders such as bulimia and anorexia nervosa long overdue, and that it will prove effective in reducing the incidence of these problems. As has been stated previously, prevention is a challenge whose time has finally come, and hopefully will be accepted by the professionals in this field.

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